

103D CONGRESS
2D SESSION

S. 1865

To amend title XIX of the Social Security Act to promote demonstrations by States of alternative methods of more efficiently delivering health care services through community health authorities.

IN THE SENATE OF THE UNITED STATES

FEBRUARY 24 (legislative day, FEBRUARY 22), 1994

Mr. McCaIN introduced the following bill; which was read the first time

A BILL

To amend title XIX of the Social Security Act to promote demonstrations by States of alternative methods of more efficiently delivering health care services through community health authorities.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Community Health Im-
5 provement Act of 1994”.

1 **SEC. 2. COMMUNITY HEALTH AUTHORITIES DEMONSTRATION PROJECTS.**

2
3 (a) IN GENERAL.—Title XIX of the Social Security
4 Act, as amended by section 13631(b) of the Omnibus
5 Budget Reconciliation Act of 1993, is amended—

6 (1) by redesignating section 1931 as section
7 1932; and

8 (2) by inserting after section 1930 the following
9 new section:

10 “COMMUNITY HEALTH AUTHORITIES DEMONSTRATION
11 PROJECTS

12 “SEC. 1931. (a) IN GENERAL.—In order to test the
13 effectiveness of various innovative health care delivery ap-
14 proaches through the operation of community health au-
15 thorities, the Secretary shall operate a program under
16 which States establish projects to demonstrate the effec-
17 tiveness of such approaches in providing access to cost-
18 effective preventive and primary care and related services
19 for various areas and populations, including low-income
20 residents of medically underserved areas or for medically
21 underserved populations. A State may operate more than
22 1 such project.

23 “(b) SELECTION OF STATE PROJECTS.—

24 “(1) IN GENERAL.—A State is eligible to par-
25 ticipate in the program, and establish a demonstra-
26 tion project, under this section only if—

1 “(A) the State submits to the Secretary an
2 application, at such time and in such form as
3 the Secretary may require, for participation in
4 the program; and

5 “(B) the Secretary finds that—

6 “(i) the application contains assur-
7 ances that the State will support the devel-
8 opment of a community health authority
9 that meets the requirements of this sec-
10 tion,

11 “(ii) the community health authority
12 will meet the requirements for such an au-
13 thority under subsection (c),

14 “(iii) the State provides sufficient as-
15 surances that the demonstration project of
16 a community health authority meets (or,
17 when operational, will meet) the require-
18 ments of subsection (d), and

19 “(iv) the State will comply with the
20 requirements of subsections (g) and (h).

21 “(2) CONTENTS OF APPLICATION.—Each appli-
22 cation submitted under paragraph (1) for a dem-
23 onstration project shall include at least the follow-
24 ing:

1 “(A) A description of the proposed commu-
2 nity health authority and of the area or popu-
3 lation that the authority will serve.

4 “(B) A demonstration that the CHA will
5 serve at least 1 geographic area or population
6 group that is designated as medically under-
7 served under section 330 of the Public Health
8 Service Act or as having a shortage of health
9 professionals under section 332 of such Act.

10 “(C) An assessment of the area’s or popu-
11 lation’s need for services and an assurance that
12 the services of the CHA will be responsive to
13 those needs.

14 “(D) A list of the items and services to be
15 furnished by the CHA under the project, bro-
16 ken down by those items and services that are
17 treated as medical assistance under the State
18 plan under this title and other items and serv-
19 ices that will be provided by the CHA (either
20 directly or through coordination with other enti-
21 ties).

22 “(E) An assurance that the CHA has en-
23 tered into (or plans to enter into) written par-
24 ticipation agreements with a sufficient number

1 of providers to enable the CHA to furnish all of
2 such items and services to enrolled individuals.

3 “(F) An assurance that the State plan
4 under this title will provide payment to the au-
5 thority in accordance with subsection (e).

6 “(G) Evidence of support and assistance
7 from other State agencies with responsibility for
8 providing or supporting the provision of preven-
9 tive and primary care services to underserved
10 and at-risk populations.

11 “(H) A proposed budget for the CHA.

12 “(3) PRIORITY.—The Secretary shall give prior-
13 ity to those applications proposing to support a
14 CHA that includes as participating providers all
15 Federally-qualified health centers serving the area or
16 population or (in areas for which there are no Fed-
17 erally-qualified health centers) all entities that would
18 be Federally-qualified health centers but for the fail-
19 ure to meet the requirement described in section
20 329(f)(2)(G)(i) of the Public Health Service Act or
21 the requirement described in section 330(e)(3)(G)(i)
22 of such Act (relating to the composition of the enti-
23 ty’s governing board).

24 “(4) PERIOD OF APPROVAL.—Each project ap-
25 proved under this section shall be approved for a pe-

1 riod of not less than 5 years, subject to renewal for
2 subsequent periods unless such approval is with-
3 drawn for cause by the Secretary or at the request
4 of the State.

5 “(c) COMMUNITY HEALTH AUTHORITY (CHA) DE-
6 FINED.—In this section, the terms ‘community health au-
7 thority’ and ‘CHA’ mean a nonprofit entity that meets the
8 following requirements:

9 “(1) The entity serves (or will serve at the time
10 it becomes operational under a project) a geographic
11 area or population group that includes those
12 designated—

13 “(A) under section 330 of the Public
14 Health Service Act as medically underserved, or

15 “(B) under section 332 of such Act as a
16 health professions shortage area.

17 “(2) The entity enrolls—

18 “(A) individuals and families who are med-
19 icaid-eligible;

20 “(B) within the limits of its available re-
21 sources and capacity, other individuals who
22 have incomes below 200 percent of the Federal
23 official poverty level; and

24 “(C) within the limits of its available re-
25 sources and capacity, other individuals and

1 families who are able to pay the costs of enroll-
2 ment.

3 “(3) Through its participating providers, the
4 entity provides or, through contracts, arranges for
5 the provision of (or, by the time it becomes oper-
6 ational, will so provide or arrange for the provision
7 of) at least preventive services, primary care serv-
8 ices, inpatient and outpatient hospital services, and
9 any other service provided by a participating pro-
10 vider for which payment may be made under the
11 State plan under this title to enrolled individuals.

12 “(4) The entity must include (to the maximum
13 extent practicable) as participating providers any of
14 the following providers that furnish services provided
15 by (or arranged by) the entity that are located in or
16 serve the area or population to be covered:

17 “(A) Federally-qualified health centers.

18 “(B) Rural health clinics.

19 “(C) Local public health agencies that fur-
20 nish such services.

21 “(D) A hospital (or other provider of inpa-
22 tient or outpatient hospital services) which has
23 a participation agreement in effect with the
24 State under its plan under this title, which is

1 located in or serving the area or population to
2 be served.

3 “(5) The entity may include as participating
4 providers other providers (which may include private
5 physicians or group practice offices, other commu-
6 nity clinics, limited service providers (such as pre-
7 natal clinics), and health professionals teaching pro-
8 grams (such as area health educational centers))
9 and take other appropriate steps, to the extent
10 needed to assure that the network is reasonable in
11 size and able to provide (or arrange for the provision
12 of) the services it proposes to furnish to its enroll-
13 ees.

14 “(6) The entity must maintain written agree-
15 ments with each participating provider under which
16 the provider agrees to participate in the CHA and
17 agrees to accept payment from the CHA as payment
18 in full for services furnished to individuals enrolled
19 with the CHA (subject to the requirements of sub-
20 section (g)(4), in the case of services furnished by a
21 provider that are described in subparagraph (B) or
22 (C) of section 1905(a)(2)).

23 “(7) Under the written agreements described in
24 paragraph (6), if a majority of the board of directors
25 of the entity has determined that a participating

1 provider is failing to meet any of the requirements
2 of the participation agreement, the board may termi-
3 nate the provider's participation agreement in ac-
4 cordance with the following requirements:

5 “(A) Subject to subparagraph (B), prior to
6 any termination of a provider's participation
7 agreement, the provider shall be entitled to 30
8 days prior notice, a reasonable opportunity to
9 correct any deficiencies, and an opportunity for
10 a full and fair hearing conducted by the entity
11 to dispute the reasons for termination. The pro-
12 vider shall be entitled to appeal the board of di-
13 rectors' decision directly to a committee consist-
14 ing of representatives of all of the entity's par-
15 ticipating providers.

16 “(B) If a majority of the board of directors
17 of the entity determines that the continued par-
18 ticipation of a provider presents an immediate
19 threat to the health and safety of patients or a
20 substantial risk of improper diversion of funds,
21 the board may suspend the provider's participa-
22 tion agreement (including the receipt of funds
23 under the agreement) for a period of up to 60
24 days. During this period, the entity shall take
25 steps to ensure that patients who were assigned

1 to or cared for by the suspended provider are
2 appropriately assigned or referred to alternative
3 participating providers. The suspended provider
4 shall be entitled to a hearing within the period
5 of the suspension to show cause why the sus-
6 pension should be lifted and its participation
7 agreement restored. If dissatisfied with the
8 board's decision, the provider shall be entitled
9 to appeal the decision directly to a committee
10 consisting of representatives of all of the enti-
11 ty's participating providers.

12 “(C) For all other disputes between the en-
13 tity and its participating providers (including
14 disputes over the amounts due or interim rates
15 to be paid to a provider), the entity shall pro-
16 vide an opportunity for a full and fair hearing.

17 “(8) The entity must be governed by a board of
18 directors that includes representatives of the partici-
19 pating providers and, as appropriate, other health
20 professionals, civic or business leaders, elected offi-
21 cials, and residents of the area or population served.
22 Not less than 51 percent of such board shall be com-
23 posed of individuals who are enrolled in the CHA
24 and who are representatives of the community
25 served.

1 “(d) DEMONSTRATION PROJECT REQUIREMENTS.—

2 The requirements of this subsection, with respect to a
3 demonstration project of a CHA under this section, are
4 as follows:

5 “(1)(A) All services furnished by the CHA
6 under the project shall be available and accessible to
7 all enrolled individuals and, except as provided in
8 subparagraph (B), must be available without regard
9 to an individual’s ability to pay for such services.

10 “(B) A CHA shall prepare a schedule of dis-
11 counts to be applied to the payment of premiums by
12 individuals who are not medicaid-eligible individuals
13 which shall be adjusted on the basis of the individ-
14 ual’s ability to pay.

15 “(2) The CHA shall take appropriate steps to
16 emphasize the provision of preventive and primary
17 care services, and shall ensure that each enrolled in-
18 dividual is assigned to a primary care physician (to
19 the greatest extent appropriate and feasible), except
20 that the CHA shall establish a process through
21 which an enrolled individual may be assigned to an-
22 other primary care physician for good cause shown.

23 “(3) The CHA must make reasonable efforts to
24 reduce the unnecessary or inappropriate use of hos-
25 pital or other high-cost services through an emphasis

1 on preventive and primary care services, the imple-
2 mentation of utilization review or other appropriate
3 methods.

4 “(4) The State must regularly provide the CHA
5 with information on other medical, health, and relat-
6 ed benefits that may be available to individuals en-
7 rolled with the CHA under programs other than the
8 State plan under this title, and the CHA must pro-
9 vide its enrolled individuals with enrollment informa-
10 tion and other assistance to assist such individuals
11 in obtaining such benefits.

12 “(5) The State and the CHA must meet such
13 financial standards and requirements and reporting
14 requirements as the Secretary specifies and must
15 prepare and submit to the Secretary an annual inde-
16 pendent financial audit conducted in accordance with
17 requirements specified by the Secretary.

18 “(6) In collaboration with the State, the CHA
19 must adopt and use community-oriented, patient-re-
20 sponsive quality assurance and control systems in
21 accordance with requirements specified by the Sec-
22 retary. Such systems must include at least an ongo-
23 ing quality assurance program that measures
24 consumer satisfaction with the care provided under
25 the network, stresses improved health outcomes, and

operates a community health status improvement process that identifies and investigates community health problems and implements measures designed to remedy such problems.

“(e) CAPITATION PAYMENTS.—

“(1) IN GENERAL.—Under a demonstration project under this section, the State shall enter into an annual contract with the CHA under which the State shall make monthly payments to the CHA for covered services furnished through the CHA to individuals entitled to medical assistance under this title in the amount specified in paragraph (2). Payment shall be made at the beginning of each month on the basis of estimates of the amounts payable and amounts subsequently paid are subject to adjustment to reflect the amounts by which previous payments were greater or less than the amount of payments that should have been made.

“(2) AMOUNT OF CAPITATION PAYMENT.—The amount of a monthly payment under paragraph (1) during a contract year, shall be equal to $\frac{1}{12}$ of the product of—

“(A)(i) the average per capita amounts expended under this title under the State plan for covered services to be furnished under the dem-

1 onstration project for similar medicaid-eligible
2 individuals for the most recent 12-month period
3 ending before the date of the enactment of this
4 section, increased by (ii) the percentage change
5 in the consumer price index for all urban con-
6 sumers (all items; U.S. city average) during the
7 period that begins upon the expiration of such
8 12-month period and ends upon the expiration
9 of the most recent 12-month period ending be-
10 fore the first month of the contract year for
11 which complete financial data on such index is
12 available, and

13 “(B) the number of medicaid-eligible indi-
14 viduals enrolled under the project as of the
15 15th day of the month prior to the first month
16 of the contract year (or, in the case of the first
17 year for which a contract is in effect under this
18 subsection, the CHA’s reasonable estimate of
19 the number of such individuals who will be en-
20 rolled in the project as of the 15th day of such
21 month).

22 “(f) ADDITIONAL STATE ASSISTANCE FOR PLAN-
23 NING, DEVELOPMENT, AND OPERATIONS.—

24 “(1) IN GENERAL.—Subject to paragraph (2),
25 in addition to the payments under subsection (e),

1 demonstration projects approved under this section
2 are eligible to have approved expenditures described
3 in paragraph (3) treated, for purposes of section
4 1903(a)(7), as expenditures found necessary by the
5 Secretary for the proper and efficient administration
6 of the State plan under this title.

7 “(2) SPECIAL RULES.—

8 “(A) LIMITATION WITH RESPECT TO ANY
9 COMMUNITY HEALTH AUTHORITY.—The total
10 amount of expenditures with respect to any
11 CHA that may be treated as expenditures for
12 administration under paragraph (1) for any 12-
13 month period shall not exceed \$250,000.

14 “(B) LIMITATION ON NUMBER OF
15 YEARS.—The number of 12-month periods for
16 which expenditures are treated as expenditures
17 for administration under paragraph (1) for a
18 CHA shall not exceed—

19 “(i) 2 for expenditures for planning
20 and development assistance, described in
21 paragraph (3)(A), and

22 “(ii) 2 for expenditures for oper-
23 ational assistance, described in paragraph
24 (3)(B).

1 “(C) NO RESULTING REDUCTION IN
2 AMOUNTS PROVIDED UNDER PHSA GRANTS.—

3 No grant to a CHA or 1 of its participating
4 providers under the Public Health Service Act
5 or this Act may be reduced on the ground that
6 activities of the CHA that are considered ap-
7 proved expenditures under paragraph (3) are
8 activities for which the CHA or the participat-
9 ing providers received funds under such Act.

10 “(3) APPROVED EXPENDITURES.—The ap-
11 proved expenditures described in this paragraph are
12 as follows:

13 “(A) PLANNING AND DEVELOPMENT.—Ex-
14 penditures for planning and development with
15 respect to a CHA, including—

16 “(i) developing internal management,
17 legal and financial and clinical, informa-
18 tion, and reporting systems for the CHA,
19 and carrying out other operating activities
20 of the CHA;

21 “(ii) recruiting, training and com-
22 pensating management staff of the CHA
23 and, as appropriate and necessary, man-
24 agement and clinical staff of any partici-
25 pating provider;

“(iii) purchasing essential equipment and acquiring, modernizing, expanding, or (if cost-effective) constructing facilities for the CHA and for participating providers (including amortization costs and payment of interest on loans); and

“(iv) entering into arrangements to obtain or participate in emerging medical technologies, including telemedicine.

“(B) OPERATIONS.—Expenditures in support of the operations of a CHA, including—

“(i) the ongoing management of the CHA, including daily program administration, recordkeeping and reporting, assurance of proper financial management (including billings and collections) and oversight of program quality;

“(ii) developing and operating systems to enroll eligible individuals in the CHA;

“(iii) data collection, in collaboration with the State medicaid agency and the State health department, designed to measure changes in patient access to care, the quality of care furnished, and patient health status, and health care outcomes;

1 “(iv) ongoing community outreach
 2 and community education to all residents
 3 of the area or population served, to pro-
 4 mote the enrollment of eligible individuals
 5 and the appropriate utilization of health
 6 services by such individuals;

7 “(v) the establishment of necessary
 8 reserves or purchase of stop-loss coverage;
 9 and .

10 “(vi) activities relating to health pro-
 11 fessions training, including residency train-
 12 ing at participating provider sites.

13 “(g) ADDITIONAL REQUIREMENTS.—

14 “(1) MANDATORY ENROLLMENT OF MEDICAID-
 15 ELIGIBLE INDIVIDUALS.—Notwithstanding any pro-
 16 vision of section 1903(m), a State participating in a
 17 demonstration project under this section may require
 18 that each medicaid-eligible resident in the service
 19 area of a CHA operating under the project is not eli-
 20 gible to receive any medical assistance under the
 21 State plan that may be obtained through enrollment
 22 with the CHA unless the individual receives such as-
 23 sistance through enrollment with the CHA.

24 “(2) CONTINUED ENTITLEMENT TO ADDI-
 25 TIONAL BENEFITS.—In the case of a medicaid-eli-

1 ble individual enrolled with a CHA under a dem-
2 onstration project under this section, the individual
3 shall remain entitled to medical assistance for serv-
4 ices which are not covered services under the project.

5 “(3) HMO-RELATED REQUIREMENTS.—A CHA
6 under this section shall be deemed to meet the re-
7 quirements of section 1903(m) (subject to paragraph
8 (1)) in the same manner as an entity listed under
9 section 1903(m)(2)(G).

10 “(4) TREATMENT OF FEDERALLY-QUALIFIED
11 HEALTH CENTERS AND RURAL HEALTH CLINICS.—
12 Payments under a demonstration project under this
13 section to a Federally qualified health center or
14 rural health clinic which is a participating provider
15 shall be made consistent with section
16 1902(a)(13)(E) for all services offered by the CHA
17 which are provided by such a center or clinic.

18 “(5) OUTSTATIONING ELIGIBILITY WORKERS.—
19 Under the project, the State may (in addition to
20 meeting the requirements of section 1902(a)(55))
21 provide for, or pay the reasonable costs of, station-
22 ing eligibility workers at appropriate service sites
23 under the project, and may permit medicaid-eligible
24 individuals to be enrolled under the State plan at
25 such a CHA or at such a site.

1 “(6) PURCHASE OF STOP-LOSS COVERAGE.—

2 The State shall ensure that the CHA has purchased
3 stop-loss coverage to protect against default on its
4 obligations under the project. If an entity otherwise
5 qualified to serve as a CHA is prohibited under
6 State law from purchasing such coverage, the State
7 shall waive the application of such law to the extent
8 necessary to permit the entity to purchase such cov-
9 erage.

10 “(h) EVALUATION AND REPORTING.—

11 “(1) CHA.—Each CHA in a State with a dem-
12 onstration project approved under this section shall
13 prepare and submit to the State an annual report on
14 its activities during the previous year.

15 “(2) STATE.—Taking into account the reports
16 submitted pursuant to paragraph (1), each State
17 with a demonstration project approved under this
18 section shall prepare and submit to the Secretary an
19 annual evaluation of its activities and services under
20 this section. Such evaluation shall include an analy-
21 sis of the effectiveness of the project in providing
22 cost-effective health care to enrolled individuals.

23 “(3) REPORT TO CONGRESS.—Not later than 3
24 years after the date of the enactment of this section,
25 the Secretary shall submit to Congress a report on

1 the demonstration projects conducted under this sec-
 2 tion. Such report shall include an analysis of the ef-
 3 fectiveness of such projects in providing cost-effec-
 4 tive health care for the areas or populations served.

5 “(i) COLLABORATION IN ADMINISTRATION.—In car-
 6 rying out this section, the Secretary shall assure the high-
 7 est possible level of collaboration between the Health Care
 8 Financing Administration and the Public Health Service.
 9 Such collaboration may include (if appropriate and fea-
 10 sible) any of the following:

11 “(1) The provision by the Public Health Service
 12 of new or increased grant support to eligible entities
 13 participating in a CHA, in order to expand the avail-
 14 ability of services (particularly preventive and pri-
 15 mary care services).

16 “(2) The placement of health professionals at
 17 eligible locations and collaboration with Federally-as-
 18 sisted health professions training programs located
 19 in or near the areas served by community health au-
 20 thorities.

21 “(3) The provision of technical and other non-
 22 financial assistance.

23 “(j) DEFINITIONS.—In this section:

24 “(1) MEDICAID-ELIGIBLE INDIVIDUAL.—The
 25 term ‘medicaid-eligible individual’ means an individ-

1 ual described in section 1902(a)(10)(A) and entitled
2 to medical assistance under the State plan.

3 “(2) PARTICIPATING PROVIDER.—The term
4 ‘participating provider’ means, with respect to a
5 CHA, a provider that has entered into an agreement
6 with the CHA for the provision of covered services
7 under a project under this section.

8 “(3) PREVENTIVE AND PRIMARY CARE SERV-
9 ICES.—‘Preventive’ and ‘primary’ services include
10 those services described in section 1905(l)(2)(A) and
11 included as Federally-qualified health center serv-
12 ices.”.

13 (b) CONTINUED MEDICAID ELIGIBILITY FOR UP TO
14 1 YEAR.—Section 1902(e)(2) of such Act (42 U.S.C.
15 1396a(e)(2)) is amended—

16 (1) in subparagraph (A)—

17 (A) by inserting “or with a community
18 health authority under a demonstration project
19 under section 1931” after “section 1876”, and

20 (B) by striking “such organization or en-
21 tity” and inserting “such organization, entity,
22 or authority”; and

23 (2) in subparagraph (B), by striking “effec-
24 tive.” and inserting the following: “effective (or, in
25 the case of an individual enrolled with a community

1 health authority under a demonstration project
2 under section 1931, of not more than 1 year begin-
3 ning on the date the individual's enrollment with the
4 authority becomes effective).”.

5 (c) EXCEPTION TO ANTI-KICKBACK LAW.—Section
6 1128B(b)(3) of such Act (42 U.S.C. 1320a-7b(b)(3)) is
7 amended—

8 (1) by striking “and” at the end of subpara-
9 graph (D),

10 (2) by striking the period at the end of sub-
11 paragraph (E) and inserting “; and”, and

12 (3) by adding at the end the following new sub-
13 paragraph:

14 “(F) any remuneration paid, or received, by a
15 Federally qualified health center, rural health clinic,
16 or other entity which is a participating provider
17 under a demonstration project under section 1931 as
18 part of an arrangement for the procurement of
19 goods or services or the referral of patients or the
20 lease or purchase of space or equipment.”.

21 (d) EFFECTIVE DATE.—The amendments made by
22 this section shall apply to calendar quarters beginning on
23 or after October 1, 1994.

1 **SEC. 3. HEALTH CENTER PROGRAM AMENDMENTS.**

2 (a) **AUTHORIZATION OF GRANTS FOR NETWORK DE-**
3 **VELOPMENT.—**

4 (1) **MIGRANT HEALTH CENTERS.**—Section 329
5 of the Public Health Service Act (42 U.S.C. 254b)
6 is amended by adding at the end the following:

7 “(j)(1) The Secretary may make a grant, to an entity
8 receiving a grant under this section or to a group of such
9 entities, to support the planning and development of
10 health service networks (as defined in paragraph (3))
11 which will serve high impact areas, medically underserved
12 areas, or medically underserved populations within the
13 area they serve (or propose to serve).

14 “(2) A grant under this subsection for the planning
15 and development of a health service network may be used
16 for the following costs:

17 “(A) The costs of developing the network cor-
18 porate entity, including planning and needs assess-
19 ment.

20 “(B) The costs of developing internal manage-
21 ment for the network, as well as costs of developing
22 legal, financial, clinical, information, billing, and re-
23 porting systems, and other costs necessary to
24 achieve operational status.

25 “(C) The costs of recruitment, training, and
26 compensation of management staff of the network

1 and, as appropriate and necessary, the management
2 and clinical staff of any participating provider.

3 “(D) The costs of developing additional primary
4 health and related service sites, including costs relat-
5 ed to purchase of essential equipment, acquisition,
6 modernization, expansion, or, if cost-effective, con-
7 struction of facilities.

8 “(3) In this subsection, the term ‘health service net-
9 work’ means a nonprofit private entity that—

10 “(A) through its participating providers (which
11 may provide services directly or through contract)
12 assures the provision of primary health and related
13 services and, as appropriate, supplemental health
14 services to residents of the high impact area or
15 medically underserved area or members of the medi-
16 cally underserved population covered by the network,

17 “(B) includes, as participating providers, at
18 least all recipients of grants under this section or
19 section 330, 340, or 340A that provide primary
20 health and related services to the residents of the
21 area it serves (or proposes to serve), and that may
22 include, at the entity’s option, any other providers of
23 primary health or supplemental health services to
24 residents of the high impact area or medically un-
25 derserved area or members of the medically under-

1 served population covered by the network, but only
2 if such participating providers agree to provide serv-
3 ices without regard to an individual's ability to pay,
4 and

5 “(C) is governed by individuals a majority of
6 whom are patients, employees, or board members of
7 its participating providers that receive grants under
8 this section or section 330, 340, or 340A.”.

9 (2) COMMUNITY HEALTH CENTERS.—Section
10 330 of such Act (42 U.S.C. 254c) is amended by
11 adding at the end the following:

12 “(1)(1) The Secretary may make a grant, to an entity
13 receiving a grant under this section or to a group of such
14 entities, to support the planning and development of
15 health service networks (as defined in section 329(j)(3))
16 which will serve high impact areas, medically underserved
17 areas, or medically underserved populations within the
18 area they serve (or propose to serve).

19 “(2) A grant under this subsection for the planning
20 and development of a health service network may be used
21 for the costs described in section 329(j)(2).”.

22 (3) EFFECTIVE DATE.—The amendments made
23 by this subsection shall take effect on the date of the
24 enactment of this Act.

1 (b) EXTENSION OF AUTHORIZATION OF APPROPRIA-
2 TIONS.—

3 (1) MIGRANT HEALTH CENTERS.—Section
4 329(h)(1)(A) of such Act (42 U.S.C. 254b(h)(1)(A))
5 is amended—

6 (A) by inserting “and subsection (j)” after
7 “through (e)”, and

8 (B) by striking “1994” and inserting
9 “1999”.

10 (2) COMMUNITY HEALTH CENTERS.—Section
11 330(g)(1)(A) of such Act (42 U.S.C. 254c(g)(1)(A))
12 is amended by striking “1994” and inserting
13 “1999”.

○

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